



Report of an inspection of a Designated Centre for Disabilities (Adults)

Issued by the Chief Inspector

Name of designated centre:	Ros Mhuire
Name of provider:	Sunbeam House Services Company Limited by Guarantee
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	17 December 2019
Centre ID:	OSV-0001706
Fieldwork ID:	MON-0024952

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Ros Mhuire is a designated centre operated by Sunbeam House Services CLG located in a small town in County Wicklow. It provides a community residential services to four people, male and female, with intellectual disabilities. The designated centre consists of two sitting rooms, kitchen, dining room, four individual bedrooms, staff bedroom, office and a number of shared bathrooms. There is a well maintained garden to the rear of the centre. The centre is staffed by a person in charge and social care workers. The person in charge works in a full time capacity and they are also responsible for a separate designated centre. Staff lone work in this centre and the provider has systems in place to support this arrangement.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4
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How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 17 December 2019	09:45hrs to 18:00hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with the four residents living in the centre. Overall, the residents spoke positively about living in the centre and the care and support they received. The inspector also observed that residents appeared content and comfortable in the centre.

Residents spoke with the inspector about the things that interested them and things they liked to do including their family, sports, hobbies and gaming. One resident spoke about the sports they enjoyed and the team they followed, their family and the staff supporting them. Another resident spoke with the inspector about their interest in video games. Other residents spoke with the inspector about their hobbies such as TV shows, music and plans for Christmas.

The inspector spent time in the dining room and kitchen of the house. The inspector observed residents as they prepared to engage with their daily activities which included accessing the community, attending meetings and day services. In addition, the inspector observed residents engaging in various activities in their home such as watching tv, accessing the local community and preparing meals. Throughout the day of inspection, the inspector observed positive interactions between staff and residents such as discussing the events of the day.

The inspector observed a number of questionnaires on the quality of care provided by the services completed by the residents representatives in early 2019, Overall, the feedback from residents' representatives were positive on the quality of care provided in the service. However, one representative highlighted a concern in relation to the staffing levels in the designated centre.

The inspector observed that the designated centre was decorated in a homely manner. However, some areas of the centre required some upkeep. The house comprised of two homely sitting rooms which were decorated with pictures of residents and Christmas decorations, four individualised bedrooms, a kitchen, dining room and a number of shared bathrooms and toilets. A number of residents showed the inspector their bedrooms which they said they were happy with and decorated in line with their tastes and preferences.

Capacity and capability

The provider's governance and management arrangements in place effectively and consistently monitored the service to ensure the effective delivery of care and support in line with the assessed needs of residents. However, some minor improvement was required to demonstrate that there was sufficient staffing levels at

all times and that families and residents were consulted with for the annual review of the service.

There was a clearly defined governance and management structure in place. The centre was managed by a full-time person in charge who was also responsible for the management of another designated centre. The person in charge was appropriately qualified and experienced and demonstrated good knowledge of the residents and their assessed needs. They were supported in their role by a deputy client services manager. There were quality assurance audits in place including six monthly unannounced provider visits and an annual review for 2018 in line with the regulations. In addition, there was evidence of a number of local quality assurance audits including health and safety audits and mediation audits. These audits identified areas for improvement and actions plans. However, some improvement was required in the annual review as it was not evident that the residents and/or their representatives were consulted in its development. The provider noted that the template for the annual review has been updated to capture this.

The person in charge maintained a planned and actual roster. The inspector reviewed a sample of rosters which demonstrated that staff lone work in this centre both morning and afternoon. It was evident that continuity of care was ensured as any gaps were covered by the use of regular staff from the second designated centre managed by the person in charge. However, the staffing arrangements required review as the provider could not demonstrate, at the time of the inspection, that there was sufficient staffing available to meet some of the assessed needs of residents at all times in the designated centre. For example, feedback from a family member reviewed by the inspector highlighted expressed concerns with the staffing levels in the designated centre. In addition, there was evidence of occasions where residents had limited choice in transport to attend social events due to the lone working arrangement in the centre and had to take a taxi.

There were systems in place for the training and development of the staff team. From a sample of files reviewed, the staff team had up-to-date mandatory training which included the safe administration of mediation, people handling and de-escalation and intervention techniques. The person in charge maintained a training schedule which ensured that the staff team had up-to-date knowledge and skills to meet the needs of residents.

The inspector reviewed a sample of adverse incidents and found that all incidents were notified to the Office of the Chief Inspector of Social Services in line with Regulation 31.

Regulation 15: Staffing

The person in charge maintained a planned and actual roster. The staffing arrangements required review as the provider could not demonstrate, at the time of the inspection, that there was sufficient staffing available to meet some of the

assessed needs of residents at times in the designated centre

Judgment: Substantially compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. The staff team were up-to-date in mandatory training which meant that the staff team had up-to-date knowledge and skills to meet the needs of residents.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined governance and management structure in place. There were quality assurance audits in place including six monthly unannounced provider visits and an annual review for 2018 in line with the regulations. These audits identified areas for improvement and actions plans. However, it was not evident that the residents and/or their representatives were consulted in the development of the annual review.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

All incidents were notified to the Office of the Chief Inspector of Social Services as appropriate.

Judgment: Compliant

Quality and safety

The governance and management arrangements in place ensured that the service provided was safe and in line with resident needs and supports. However, some improvements were required in premises and oversight of restrictive practices.

The inspector reviewed a sample of personal plans and found that each resident had

an up-to-date assessment of need in place which consisted of support needs assessment, a personal plan assessment and a health and well being assessment. These assessments of need identified residents' health and social care needs and informed residents' personal support plans. From a sample of plans reviewed, the inspector found that the plans in place were up-to-date and guided staff to support residents with identified needs.

Residents health care needs were identified and managed to an adequate standard. All residents had received an annual health check by their General Practitioner (GP). Residents were supported to manage their health care conditions and there was evidence that residents had regular access to appropriate allied health professionals.

There were positive behaviour support plans in place for residents who required support to manage their behaviours. The inspector reviewed a sample of the positive behaviour support plans and found that they were up-to-date and adequately guided the staff team. Residents were supported to enjoy their best possible mental health and, where required, had access to psychiatry and psychology. There was some restrictive practices in use in the designated centre. While the restrictions had been identified and reviewed by the person in charge, the restrictions were not reviewed by the provider's Human Rights Committee in a timely manner.

Residents told the inspector that they were happy in the centre and were observed to appear comfortable in their home. The inspector reviewed a sample of adverse incidents and found that they were managed appropriately. Staff spoken with were clear on what to do in the event of an allegation or concern. Throughout the day of the inspection, positive interactions were observed between residents and the staff team.

The inspector completed a walk through of the designated centre accompanied by the person in charge. Overall, the designated centre was decorated in a homely manner. The previous inspection identified areas of the premises which required review and these had been addressed by the provider. However, some areas of the centre were observed to require attention including painting and flooring in the hallway.

There were systems in place for the assessment, management and ongoing review of risks in the designated centre. The centre maintained an up-to-date risk register which detailed centre specific risks including lone working. In addition, individual personal risk assessments were in place including management of behaviours that challenge and the development of skills and independence.

The centre had suitable fire safety equipment in place including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. Each resident had a Personal Emergency Evacuation Plan (PEEP) in place as appropriate which outlined the supports for each resident to evacuate the designated centre. There was evidence of regular fire drills and learning from fire drills to ensure the safe and timely evacuation of all persons in the designated centre in the event of a fire.

There were suitable practices in place in relation to the ordering, storage, administration and disposal of medicines. Medication was found to be stored in a secure locked press. A sample of prescription and administration sheets were viewed and found to contain appropriate information. There was evidence that the provider consulted with residents in relation to self administering medication. For residents who self administered medication there was appropriate supports in place for these residents.

Regulation 17: Premises

Overall, the designated centre was decorated in a homely manner. However, some areas of the centre were observed to require attention including painting and flooring in the hallway.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were systems in place for the assessment, management and ongoing review of risks in the designated centre. The centre maintained an up-to-date risk register and individual personal risk assessments which outlined the controls in place to manage risk in the centre.

Judgment: Compliant

Regulation 28: Fire precautions

The centre had suitable fire safety equipment in place. Each resident had a Personal Emergency Evacuation Plan (PEEP) in place and there was evidence of regular fire drills and learning from fire drills to ensure the safe and timely evacuation of all persons in the designated centre in the event of a fire.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There were suitable practices in place in relation to the ordering, storage, administration and disposal of medicines. Residents were consulted with to take

control of their own medication. For residents who self administered medication there was appropriate assessment of capacity and storage in place for these residents.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had an up-to-date assessment of need in place which consisted of support needs assessment, a personal plan assessment and a health and well being assessment. These assessments of need identified residents' health and social care needs, informed residents' personal support plans and guided the staff team in supporting the residents.

Judgment: Compliant

Regulation 6: Health care

Residents health care needs were identified and managed to an adequate standard. Residents were supported to manage their health care conditions and there was evidence that residents had regular access to appropriate allied health professionals.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were positive behaviour support plans in place for residents who required support to manage their behaviours. Residents were supported to enjoy their best possible mental health and, where required, had access to psychiatry and psychology.

There was some restrictive practices in use in the designated centre which were not reviewed by the provider's Human Rights Committee in a timely manner.

Judgment: Substantially compliant

Regulation 8: Protection

There were systems in place to safeguard residents. Residents told the inspector that they were happy in the centre and were observed to appear comfortable in their home. The inspector reviewed a sample of adverse incidents and found that they were managed appropriately. Staff spoken to were clear on what to do in the event of an allegation or concern.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Ros Mhuire OSV-0001706

Inspection ID: MON-0024952

Date of inspection: 17/12/2019

Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant** - A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.
- **Not compliant** - A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider’s responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider’s response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Provider and Pic will review the staffing levels at the centre quarterly to review if current staffing levels are appropriated in meeting the assessed need of the residents. Residents will be reminded and supported at their regular residents’ meetings to raise any concerns around impacts that staffing levels may have on their needs.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The provider has implemented a new process which will ensure consultation for residents and their representatives is included as part of the Annual review.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: All maintenance requests for areas requiring attention are now logged on the providers internal software platform. The PIC will ensure there are regular updates recorded on the status of these requests.	

Regulation 7: Positive behavioural support	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:</p> <p>All right restrictions and restrictive practices in place have now been reviewed by the Human Rights committee. There is a new process in place to ensure all rights restrictions and restrictive practices are reviewed in a timely manner.</p>	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	17/01/2020
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/04/2020
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide	Substantially Compliant	Yellow	17/01/2020

	for consultation with residents and their representatives.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	17/01/2020